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Richard Cabada  
The Subjective Experience of Attachment  
for Children with Mothers who have been  
Formally Diagnosed as Schizophrenic:  
An Exploratory Study Based on the  
Practice Wisdom of Clinical Practitioners

ABSTRACT

This qualitative study explored what could be learned from the practice wisdom of clinical practitioners about the subjective experience of attachment for children that have been raised in a family where the primary caretaker was a mother formally diagnosed as schizophrenic. Most of the literature on this subject has addressed this mother-child dyad by focusing on the subjective experience of the mother.

The sample was comprised of eight licensed clinical practitioners that generated nine cases with ten children for discussion. The mothers in all cases experienced multiple hospitalizations and most were single parents. The children in all cases experienced physical and emotional neglect and violence either directed at the child or with the child as observer. All of the children had axis one diagnosis.

Major findings were that the children clearly perceived that something was wrong with their mothers in childhood although they did not grapple with the formal diagnosis of schizophrenia until adolescence. Three strategies to cope with the mother's illness were identified all of which were considered adaptive: detachment/dissociation, hyper-vigilance and projection. It would be important to explore how typical these three strategies are for this population and whether more strategies can be identified in future study.

The findings in this study pointed out the tremendous need for more research on this population, both quantitative and qualitative.

THE SUBJECTIVE EXPERIENCE OF ATTACHMENT FOR CHILDREN WITH  
MOTHERS WHO HAVE BEEN FORMALLY DIAGNOSED AS SCHIZOPHRENIC:  
AN EXPLORATORY STUDY BASED ON THE PRACTICE WISDOM OF CLINICAL  
PRACTITIONERS

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Masters of Social Work

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2008

## ACKNOWLEDGMENTS

I would like to acknowledge some very special people without whom this study could not have been completed:

To my mother, Maria Petra Cabada Aguiar: It took eight and a half restless months and a totaled car, but it was nice to see you again!

To my brother Victor Cabada: Although you're not around much, this one's for the both of us!

To Cassie Fox-Percival: You'll hate this acknowledgement but you know you were the most important piece my search in Los Angeles. Thank you!

To Dr. Alex Kopelowicz, Fortney Carter & Detective Aduato: Thank you for all your help in recruiting participants and finding my mother throughout the thesis process.

To Dr. Ruth Finkel and Dr. Mary Hall: Thank you for editing my work and providing emotional support throughout the thesis process.

To Thesis Support Group: Thank for the privilege and support during our meetings while in field placement.

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## CHAPTER I

### INTRODUCTION

A substantive body of literature has accrued about the high incidence of attachment insecurity among children reared by schizophrenic mothers (Cunningham, Harris, Vostanis, Oyebode & Blissett, 2004). Most of this literature has been either quantitative (Hans, Auerback & Styr; 2004; Jogeusen et al., 1987), or longitudinal (Sroufe, 2005; White, Nicholson, Fisher; 1995) and case studies (Hatfield, Mohamad & Webster 1997; Powell, 1998). The latter are more qualitative in design and based on the practice wisdom of clinical practitioners working with the mother and/or family in treatment. The major trend in this literature has been to address the mother-child dyad by focusing on the subjective experience of the mother. In contrast, very little attention has been paid to the subjective experience of the child in the mother-child dyad. Thus, we know relatively little about how the child comes to know and make sense of their relationship with the mother; and what strategies such children develop to negotiate their attachments to them.

According to Dr. Alex Kopelowics, a leading researcher in schizophrenia at the University of California, Los Angeles (UCLA) School of Medicine and Medical Director of the San Fernando Mental Health Center (SFMHC), there are no current statistics indicating how many children experience being reared by a schizophrenic mother because it is such a neglected issue (personal communication, February 23, 2008). We



also do not have good demographic data about what happens with this population if the schizophrenic mother is unable to care for her child/children (Mowbray et al, 1995). We do know that out of the population diagnosed with schizophrenia, women are more likely than men to be responsible for child care (Psychiatric Bulletin, 2004). Low income and single parent female headed households are, in turn, thought to be particularly vulnerable and at increased risk for all sorts of social and emotional disorganization (Webster, 1992).

It is estimated that about 1.1 percent of the U.S. population age 18 and older, or approximately 2.4 million American adults in a given year, have been formally diagnosed with some form of schizophrenia (Narrow, 1993; The National Alliance for Research on Schizophrenia and Depression, 2008). The prevalence of this disease is thought to range from 0.5% to 1.5% worldwide (DSM-IV-TR, 2000). Schizophrenia affects both sexes with almost equal frequency with men being affected slightly more than women (Regier, 1991; DSM-IV-TR, 2000).

Schizophrenia has been one of the most studied mental disorders according to the American Psychiatric Association's most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000). The diagnosis of schizophrenia requires that continuous signs of the illness have lasted for at least 6 months and must include at least one or more of the following symptoms: delusions, hallucinations, disorganized speech, language, thought processes, and disorganized self-monitoring of behaviors (DSM-IV-TR, 2000). It is a mental disorder with subtypes, e.g., paranoid, disorganized, catatonic, delusional/ brief psychotic, shared psychotic, drug induced, and not otherwise specified (DSM-IV-TR, 2000). Schizophrenia always involves some deterioration from a previous

level of functioning in some or all phases of life, i.e., work, social relations, family engagements and self-care. Between episodes of active illness, the degree of disability can range from no disability to disability so severe that institutional care is required.

Research studies continually link children reared by schizophrenic mothers with high incidences of insecure attachment patterns throughout their lives (Naslund et al, 1984; Davies, 2004). Furthermore, studies consistently show a correlate between insecure attachment styles and multiple negative behavioral and consequential outcomes, including psychopathology and altered peer relations (Dellisch, 1989; Kinniburgh, 2005).

According to the literature, without a secure attachment with a parent, or substitute parent figure, to help soothe, comfort and reassure the child, the child's emotional stress is compounded. This in turn leaves the child more prone to experience intense conflicted emotions and seek disengagement which only intensifies the sense of isolation (Johnson & Whiffen, 2003). Secure attachment styles provide an emotionally secure base from which children can entertain and explore a wide range of emotional states that can arise in social relations and situations beyond the immediate family, e.g., other family members, friends, school or work (Allen, 2001). Insecure attachments styles, on the other hand, inflict anxiety on an individual when attempting to negotiate new social situations and relationships with others. They can lead to withdrawing behavioral characteristics which can perpetuate isolation from others. The isolation in turn may cause depression or other negative behavioral characteristics thereby inducing more emotional pain (Allen, 2001).

It has been suggested that children with schizophrenic mothers experience insecure attachments due to their caregiver's lack of emotional attunement (Powell 1998;

Allen 2001). Children of severely disturbed parents tend to grow up feeling isolated from their peers and in their community because of the stigma associated with their parent's illness (Dunn, 1993; Kinniburgh, 2005). Any emotional and/or behavioral problems that occur in this population during childhood are most frequently attributed to the mother's inability to perceive and appropriately respond to their child's need for a secure attachment and protection (Bowlby, 1988 in Oppenheim, Goldsmith, & Koren-Karie, 2004).

Thus as these children grow to become adults they develop atypical attachment patterns that diminish both their tendency to seek support and their perception of support from others (Florian, 1995). As a result, their development of emotional trust and openness to other relationships is further impeded. The emotional unavailability experienced in a relationship with a person with insecure attachments can also become part of a self-perpetuating cycle which harms other people in the relationship. For example, a parent with insecure attachments can pass their emotional distress onto their child (Cassidy & Berlin, 1994).

Since the primary emphasis in research on this population has tended to be on the schizophrenic mother's subjective experience attaching to their children (Hatfield, Webster & Mohamad; 1997; Bosanac, Buist & Burrows; 2003), the literature has tended to be overwhelmingly problem focused and not strength based. Thus we know relatively little about the subjective experience of the child. This qualitative study was designed to make a contribution to filling this gap in the literature by exploring what we can learn from the practice wisdom of clinical practitioners about how children raised by schizophrenic mothers come to know and make sense of their relationship with their

mother; and what strategies such children develop, that may or may not be adaptive, in response to their mother's attachment issues.

## CHAPTER II

### LITERATURE REVIEW

#### *Schizophrenia as an Illness*

According to the American Psychiatric Association's most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), schizophrenia is a psychotic disorder. Psychotic disorders are characterized by delusions, prominent hallucinations, disorganized speech, and/or catatonic behavior experienced during any given period of time in a person's life (2000). Psychotic disorder subtypes are: schizophrenia (paranoid, disorganized, catatonic, undifferentiated, or residual type), schizophreniform, schizoaffective, delusional/ brief psychotic, shared psychotic, psychotic disorder due to general medical condition, substance-induced psychotic disorder, and psychotic disorder not otherwise specified.

Among the psychotic disorders, schizophrenia, schizophreniform, and schizoaffective subtypes are the most commonly known. Schizophrenia is characterized by a psychotic disturbance that lasts for at least six months and includes at least any two psychotic symptoms for a period of one month (DSM-IV-TR, 2000). Schizophreniform, another known subtype of the psychotic illnesses, exactly like schizophrenia except that its duration is only one to six months (Schizophrenia Bulletin, 2004). Lastly, schizoaffective disorder consists of a mood episode followed or preceded by an active phase of psychotic symptoms approximately two weeks apart (DSM-IV-TR, 2000).

Psychotic symptoms experienced in schizophrenia can be both positive and negative. Negative symptoms reflect diminution or loss of normal function. These include restrictions in range and intensity of emotional expression (affective flattening), restriction in fluency of thought and speech (alogia), and restriction of initiation of goal directed behavior (avolition). In contrast, positive symptoms refer to an excess or distortions of normal functions such as: distortions in thought content, (delusions), perception (hallucination), language and thought processes (disorganized speech), and self-monitoring of behavior (grossly disorganized or catatonic behavior). Also included are cognitive difficulties such as disorganized thoughts, difficulty concentrating and/or following instructions, difficulty completing tasks, difficulty with memory problems, and loss of reality testing (Schizophrenia Bulletin, 2004).

People experiencing a psychotic disorder either have very little or no insight with regard to their mental disability (Peralta & Cuesta, 1994). A study performed by Lena Flyckt, et al. (1999) exploring insight among a group of schizophrenic patients found that 50% of the patients in their study did not know their diagnosis and roughly 30% did not know the reason why they were taking their anti-psychotic medications.

It is widely accepted that approximately one percent of the American population suffers from some form of psychotic disorder (The National Association of Mental Illness, 2003). The most recent DSM-IV-TR (2000) estimates the worldwide prevalence of this disorder to range from 0.5% to 1.5%.

In short, schizophrenic disorders are among the most chronic mental disorders and usually require special attention by clinical practitioners during the active phase of negative or positive symptoms. They impinge on the person's everyday life, weakening

them in the performance of the simplest tasks. For this reason, people diagnosed with schizophrenia “has a higher risk of unemployment, poor self-care, exploitation, homelessness, and life-disruption due to psychotic episodes” (Davies, 2004, p. 89).

### *Rates of Children Raised by a Schizophrenic Mother*

There is currently a lack of research determining the frequency of schizophrenic women rearing children (Apfel & Handel, 1993; Bosanac, Buist, & Burrows, 2003). That this is the state of affairs is further indication of the limited attention this population has received in the literature (personal communication, February 23, 2008). Thus there are a lot of unanswered questions. For example, are these primarily single parent families, or is the father or other kin present? How do children who are reared by their mothers compare to those who are removed from the home and placed in foster care or with other relatives? To what extent do mothers with schizophrenic disorders retain responsibilities for their children even if they do in fact rear them (Mowbray et al., 1995).

There has been some research that suggests that out of the schizophrenic population, women are more likely than men to be involved in child care. For example, a study involving 551 Mental Health Act assessments indicated that 72% of mentally ill parents living with dependent children were women (Hatfield, et al, 1997). McGrath et al. (1999) reported that 59% of women serviced by community health centers were mothers.

We do know that there are approximately 1,200,000 schizophrenic women in the United States. An unsupported single parent family consisting of a lone mothers as sole income providers is a particular vulnerable family unit both economically and

emotionally (Webster, 1992). White et al. (1995) has suggested that only 9% of women with severe mental illnesses including clinical depression, bi-polar, and psychotic disorders are primary caregivers for their children. Although this is only a small portion of the U.S. when considering an overall population of 300,000,000, it is important to take into account that the literature suggests this is a population that is at high risk for disruptions in their primary attachment with their mothers and to develop insecure attachment styles.

### *Attachment Styles and their Significance*

Attachment is a term that describes the emotional bond a person forms and his way of relating with other people. A person's first experience of this bond is with his caretakers. The bond is established at birth and plays a crucial role in determining future relationships with others (Sable, 2000). Thus, the first attachment figure an infant ever experiences, usually a parent, plays a vital role in shaping that person's behavioral patterns and perceptions regarding relationships with others.

The central function of the initial attachment relationship with the parent is to provide an emotionally secure base from which the child can explore a wide range of emotional states that can arise when he or she is learning to live as a relatively autonomous adult (Allen, 1999). It is this initial bond that establishes a person's sense of security over time and allows him or her to feel a positive sense of self in the world. This positive sense of self is a prerequisite to establishing good social relationships. These behavioral perceptions regarding the self in relationships with others have a long standing



impact on the development of identity, personal agency, and the capacity to regulate emotion (Kinniburgh, 2005).

There is general consensus in the literature that there are three forms of attachment styles. The first is secure attachment in which a child actively utilizes his or her caregivers at times of distress in order to reduce anxiety arising from external stimuli (Muris, Meyer, Meesters, 200). The second is avoidant attachment where the child avoids or becomes reluctant to attach with others (Allen, 2001; Vitz & Lynch, 2007). And lastly, ambivalent attachment which is recognized when a child accepts emotional bonds with others at certain points while actively refusing them at others with little or no coherence (Cassidy & Berlin, 1994; Vitz & Lynch, 2007). (A fourth attachment style known as disorganized/disoriented attachment characterized by interruptive bouts of disorganized and/or disoriented behavior has been identified but has not yet been fully researched thus it is currently set aside for now (Main & Salomon, 1986, 1990).) According to research, 65% of the population has a secure attachment style while 25% and 10-15% have avoidant and ambivalent respectively. (Vitz & Lynch, 2007).

Ambivalent and resistive/avoidant forms of bonding and relating to other people are considered insecure attachment styles. They are commonly experienced in a disorganized and anxious manner (Allen, 2001). Frightening or traumatizing behavior on the caregiver's part usually plays a determinant role in the development of this attachment style (Main & Hesse, 1990; Muller et al., 2000). People experiencing insecure attachment tend to have difficulties regulating a secure sense of self. This further impedes development of the emotional security necessary to form other secure

attachments thus making it difficult to form any cohesive attachment strategy when encountering prospective relationships.

In regards to secure attachment styles, Pat Sable posited in her work, *Attachment and Adult Psychotherapy*, that “Children who feel loved and wanted by their caregivers and other significant attachments [were] more apt to feel confident that others will find them lovable too; as adults they will feel lovable and capable of establishing satisfactory relationships (2000, p.23). An emotional pattern of accepting and being accepted established in the parent-child relationship gave the child the emotional tools and reference of usage in order to facilitate later relationships in life.

### *The Psychodynamics of Attachment*

Donald Winnicott understood the initial attachment relationship between mother and child as a necessary discourse providing the child with the emotional tools to establish a secure sense of self with others as well as in solitude. He posited that the only way for a child to have a strong enough sense of him or herself as an autonomous agent was by first securing his or her abilities to attach to others in order to internalize a sustaining presence of everybody intra-psychically (Berzoff, Flanagan, & Hertz, 2002). This meant that the ability to be together with others required the prerequisite of enjoying solitude. It also meant that enjoying solitude required the ability to retain a relationship of others within the self.

Winnicott extrapolated this notion of continual interplay between a person’s need for attachment along with separateness in the process of personal development by observing infants as they developed over time. During his investigations, Winnicott

noted that at the very beginning of life an infant thrived with a maternal attachment figure who could allow herself to merge into a secure union and total merger (Winnicott, 1960). An emotionally attuned mother would allow herself to be lost in her preoccupation with her baby. Her abilities to take care of her child in this manner were necessary to ensure its optimal psychological development

Winnicott believed that healthy emotional attachments required nurturance from what he referred to as a “good enough” mother. By “good-enough,” he referred to the ability to properly attune to the baby’s changing developmental needs. Healthy emotional development as defined by Winnicott was achieving a secure sense of self as an autonomous agent in the world (Berzoff, Flanagan, & Hertz, 2002). In order to achieve this state, a person needed to have a sense of “good-enough” nurturance from its caregiver along with a vehicle from the external world to aid it become an autonomous agent. This vehicle was referred to as the “transitional object.” It was a means to cross the gap from complete child-care giver union towards an autonomous self. It resembled anything from the previous safe space of the original attachment relationship with the mother, for example: a t-shirt, blanket, teddy bear, and so forth (Berzoff, Flanagan, & Hertz, 2002).

As the child’s emotional development progressed and the infant began to recognize his or her own separateness, the mother-caregiver union gradually dissipated over time. It was during these stages of emotional development that the child’s sense of individuality grew. Having a sense of being in a “good-enough holding environment”, was initially necessary, but gradually and subtly became less protective with the intent of not being overly impinging or limiting (Berzoff, Flanagan, & Hertz, 2002). This

environment gave the baby the ability to feel safe both physically and emotionally while still allowing it to explore its surrounding environment.

The gradual withdrawal of the “good-enough holding environment” promoted the child’s emotional development by not only allowing it to interact within its external world autonomously, but also letting it explore its intra-psychic self. This was necessary for development because there were many internal emotional conflicts deriving from the child’s disclosure of itself in its new environment. It then became the caretaker’s task to not only ensure a protective environment in regards to its external surroundings, but also from the internal conflicts within the child itself (Winnicott, 1945).

Achieving the ability to tolerate and enjoy solitude by creating a presence with another who was experienced distinctly from the person was vital according to Winnicott. This was an attachment style that was flexible as well as nurturing in the sense of “good-enough” in order to develop the “True Self” which was understood as the repository of uniqueness and individuality. Winnicott believed that if the holding environment became a limiting rather than expansive force while the mother and environment could not fully attune to the child’s needs, then a “False Self” would emerge. This “False Self” suppressed individuality and molded itself to the needs of others. It was seen as a sense of self that instead of embracing uniqueness, idiosyncrasy, and difference, submerged itself in a state of responsiveness taking care of others ultimately becoming too compliant and stripping away its sense of special self recognition (Berzoff, Flanagan, & Hertz, 2002).

For Winnicott, the only way for a person to enjoy autonomy was to have the ability to actualize an attachment with others (Winnicott, 1960). Actualizing of a healthy

sense of self required an attachment style involving the capacity to be together as a prerequisite for the ability to be alone and enjoy solitude. Establishing a secure sense of attachment for the child became the care-takers highest responsibility in order to safeguard its emotional development.

Margaret Mahler also formed a concept of a healthy autonomous self that existed with an attuned environment that greatly contributed to shaping its attachments. But unlike Winnicott, Mahler depicted a self that acted more independently with its world. She sought to understand the sources of the distortions the ego interpreted as it related to its world via early maternal relationships (Flores, 2001). She focused on the dynamics between developmental arrest and object constancy as it related to the individual understanding of itself. Secure attachment involved a sense of self that was confident enough to disclose itself autonomously. This became the best tool to achieve self-sufficiency (Berzoff, Flanagan, & Hertz, 2002).

She stressed how children made attachments to significant others, internalized these attachments, and became autonomous individuals through a process she called “separation-individuation.” Separation was the process that led a growing child to experience him or herself as a unique and autonomous individual. Individuation was the process of a child detaching itself both psychologically and emotionally from the child-caregiver union (Berzoff, Flanagan, & Hertz, 2002). In this process a child began to recognize itself as a unique individual with distinct self-knowledge about the traits, qualities, characteristics, and idiosyncrasies that made one unique.

Mahler mapped out the process of the self individuating in the following developmental phases: 1) The autistic phase which occurred from birth to approximately

12 weeks of age. It was seen as a phase of “objectlessness” and “selflessness” for the child because it experienced complete un-relatedness and non-meaning within itself and its world. 2) The symbiotic phase occurring from 6 weeks to 10 months of age and was characterized by a mother and child living together strongly fused as if they were in one unit or orbit (Berzoff, Flanagan, & Hertz, 2002). This stage is permeated with extreme safety and nurturing on the care-giver’s part. 3) The separation-individuation proper phase is the final phase and was depicted as having multiple smaller stages: a) differentiation, b) practicing, c) rapprochement, and d) on-the-way-to-object-constancy (Greenberg & Mitchell, 1983; Mahler et al, 1975).

a) In the Differentiation stage (5-6 months-10-12 months), the baby began to comprehend itself as a separate entity from its attachment figure by exploring its external surroundings (Greenberg & Mitchell, 1983). Related to this stage was the baby’s ability to crawl, creep, roll, and so forth away from the caregiver and explore the world on its own. The caregivers were still important for the baby but they were not the center of the universe the way they once were.

b) In the practicing stage (10-12 months-16-24 months), increased control of the body allowed the child to walk which allowed it to move alone both towards and away from the attachment figure. This eventuated in a new set of cognitive abilities, mainly those allowing the child to learn on its own. This development also consisted of the child’s tendency to triumph independently and develop a sense of exhilaration, grandiosity, omnipotence, and narcissism (Berzoff, Flanagan, & Hertz, 2002). Since the child’s new world became a very frightening and tiring place from time to time, the attachment figure was needed to give “emotional refueling” as Mahler put it (Greenberg

& Mitchell, 1983). The attachment figures' most critical role in this stage was to allow for the child's eventual disillusionment from grandiosity to be gradual so that some of the power and exhilaration of this phase remained available throughout the child's life cycle (Berzoff, Flanagan, & Hertz, 2002).

c) The rapprochement stage, which had no specific age set, was the most complicated, entailing both the child and caregiver. It stressed the importance of the child's need to experience separation, loss, and clinginess with its caregiver as it explored the world on its own (Mahler et al., 1975). This dynamic required the attachment figure to be both optimally frustrating and gratifying to the child in order to reflect amiable exploration practices while still maintaining symbiosis.

d) The last stage of separation-individuation was called "On the Way to Object Constancy." In this stage the child developed the perception of its primary attachment relationship as an entity in the psyche with relatively stable, benign, and positive representations in the face of absence, disappointment, or anger (Berzoff, Flanagan, & Hertz, 2002). Eventually this sense of emotional constancy would carry over to other relationships as well. This developmental feat gave the newly formed autonomous self the ability to cope in a world that didn't necessarily attune to it.

John Bowlby (1988) believed that object constancy required a "secure base" for the self to return to whenever stressors from the external world threatened its emotional security. In adulthood, this emotional base was sourced by the self's ability to respond to attachment figures in the external world (Bowlby, 1988). Attachment, then, was not as constant throughout adulthood as both Mahler and Winnicott had concluded. And

because of its fluctuating nature sensitively reacting to the environment, a secure base was needed for the self to return to in order to protect itself.

There is a strong consensus in the literature that insecure attachment is a poor adaptive tool because it impedes the person's ability to establish secure relationships with others (Allen, 1999). Secure attachments, on the other hand, have been linked to numerous positive outcomes and are significant predictors of resilience, especially among high-risk populations. People with poor attachment tend to show a strong correlation with negatively viewed behavioral patterns in society. These negative behavioral patterns lead to adverse effects in relationships with peers which persist throughout adulthood unless therapeutic interventions take place. In short, secure nurturing and consisting care-giving promote skill development and a safety net for coping with difficult experiences while the opposite is true for those with insecure attachment patterns.

### *Schizophrenia and Motherhood*

Studies focusing on mothers that have been diagnosed with schizophrenia have found that their children for the most part are negatively impacted. These mothers experience affective distress and psychological neediness which interferes with optimal parenting, imposing special emotional demands on the child (Radke-Yarrow, Zahn-Waxler, Richardson, Susman, & Martinez, 1994).

According to Jon Allen (2001), the precursors of attachment in the mother-infant interaction not only foster neurological and psychological regulation but also found the attachment relationships that later promote emotional-behavioral patterns. How these emotional-behavioral patterns are established with attachment figures early in life



influences future relationships with others. The role of the mother as caretaker plays imperatively in the psychological development of the child. This places a strong burden on schizophrenic mothers who cannot provide adequate emotional support in the mother-child dyad due to their inability to cope with their own illness generated.

It has been noted in the literature that “being mothered...is the most important thing for the psychobiological development of the infant” (Kreamer, 1999, p. 376). This is because the child’s influences derived from the mother attachment from infancy onward determine the cognitive skills equipping him or her for survival in the world. Extensive research indicates that failure to promote early mother-infant behavioral and emotional regulation promotes failure of subsequent emotional and behavioral self-regulation in the infant’s future life. The research posits that people who grow up with poor behavioral and regulatory attachment patterns show a high incidence of attachment insecurity or anxious attachment styles (Hofer, 1995; Kraemer, 1999; Taylor, 1992). Children reared by schizophrenic mothers have been found to grow up with inadequate attachment pattern experiences (Cunningham, Harris, Vostanis, Oyebode & Blissett, 2004).

Schizophrenic mothers are thought to stimulate attachment insecurity in their infants because they cannot provide proper emotional interaction or adequately engage them in a physical manner (Powell, 1998). Factors disturbing the mother interaction in the relational dyad are their inability to make proper eye contact, pick up stimulation in the environment, and reciprocate cues or notice discordance necessary for emotional development (Seifer et al., 1993). Observational studies overlooking the mother-infant interaction further conclude that schizophrenic mothers’ psychotic symptoms severely

impair their abilities to consistently express positive behaviors in a synchronous and contingent manner which is vital for the development of secure attachment (Brazelton et al., 1990).

An exemplary case study focusing on a psychotic mother's deficiencies as a care taker leading to her child's attachment insecurity was reported in 2002 by Karl Heinz Brisch. A woman by the pseudonymous name of Mrs. F was referred to this study after experiencing post-traumatic psychosis directly after labor with her newborn infant. During the study, especial emphasis was placed on her schizophrenic symptoms which hindered her from attending to her child. She was occasionally unreliable for "caring" and was experienced by observers as being very changed and withdrawn. It was noted that she treated her child as a doll, becoming involved with her when she felt like it but then abruptly putting her down for no explainable reason (Brisch, 2002). Not only was the pattern of mothering inconsistent, but it was responsive/dependent on the need state of the mother rather than any emotional attunement to the child. The study concluded that Mrs. F's child experienced attachment insecurity due to the mother's inability to provide her with emotional security and regulation.

The inability on the part of schizophrenic mother to model secure attachment behaviors for their children has lasting cognitive, emotional, behavioral and social consequences for infant development. These lasting negative effects play out during each child's lifetime impacting their social relationships and further determining their personal identity (Allen, 2001).

*Attachment Insecurity among Children Raised by a Schizophrenic Mother*

Current research observing households where the primary caretaker is a mother formally diagnosed with a schizophrenic disorder consistently concludes that children in this environment tend to run higher instances of insecure attachment experiences (Naslund et al, 1984; Davies, 2004). Avoidant personality disorders which are associated with this attachment style are also prevalent among this population. One study found that these children ran a 12.2% increased risk of developing avoidant personality disorder as apposed to 2.7% from those who were parented by a non-schizophrenic (Hans et al., 2004). This same population not only showed higher levels of social incompetence but also aggressiveness when compared to those raised by non-schizophrenic parents (Weintraub & Neale, 1984). Studies have associated these factors with the child's increased risk of developing the same mental disorder as the mother (Jogeusen et al., 1987; Sroufe, 2005).

It is noted that reasons accounting for such higher risks derive from schizophrenic mothers' experiences of affective distress and psychological neediness. These experiences interfere with optimal parenting and further impose special emotional demands for children's present and future lives (Radke-Yarrow, Zahn-Waxler, Richardson, Susman, & Martinez, 1994). Furthermore, other emotional tools necessary for survival within society which are also passed down through the parent-child relationship lack in development (Harwood, 1992). These impinged emotional demands along with counter-parting deficits lead to social incompetence negatively viewed by others.

Children reared by schizophrenic mothers tend to experience higher risks of dissonance with society in regards to their acceptance. Furthermore, children with insecure attachment styles run greater risks of experiencing delinquent behaviors because they have no particular orientation to others they attach to (McElhaney et al., 2006). The lack of ability to make meaningful friendships causes difficulty for this population to make attachments they can use to help them orient to social norms that are usually perceived as safe.

According to studies, children with insecure attachment styles show low levels of self-soothing in instances of exogenous stress (Walker & Emory, 1983; American Psychiatric Association, 2000). They also show undue focus on caregivers or caregiver figures when minimal external stressors arise and/or may show ineffective measures to alleviate distress (Cassidy & Berlin, 1994). These factors highly compromise exploration outside the familiarity of the caregiver by causing the children to be more vigilant to their surroundings and others.

Experiencing little enthusiasm in regards to engaging in new tasks is very common for children with insecure attachment. It is also common for them to become easily frustrated with weak efforts along with tendencies to be petulant, fussy and/or whine. Insecurely attached children have difficulties accomplishing tasks, are less liked, and have lower capacities to self-alleviate when in distress (American Psychiatric Association, 2000; Sroufe, 2005). These characteristics are seen more dramatically in children reared by psychotic parents (Hans et al., 1999).

Insecurely attached children are less regarded and seen as more emotionally vulnerable by teachers in school settings. They are seen as more needy and inept,

requiring more assistance from authority figures in accomplishing tasks and engaging with others when compared to those who are securely attached. There are higher frequencies of dependency or clinginess to authority figures among this population (Radke-Yarrow, Cummings, Kuczynski, & Chapman 1985; Sroufe, 2005). This population has been shown to need extra physical attention from caregivers and/or authority figures because they expect rejection, inconsistency, or unavailability from them (Ainsworth, 1979; Main & Weston, 1982). Such characteristics lead to internalized behavioral patterns consisting of difficulties trusting and establishing relationships with peers in the future. The constant distress at not being able to trust along with difficulties in engaging with others leads to further anxiety (Radke-Yarrow, Cummings, Kuczynski, & Chapman, 1985).

Insecure attachment styles commonly lead to less flexible behaviors in typical circumstances. This leads to more isolated or aggressive behaviors, impulsiveness and unresponsiveness to socialization, less cooperation and/or undue reliance on caregiver figures for nurturance or guidance (Sroufe, 2005). Children experiencing insecure attachment show less self confidence which is a necessary factor for the capacity to remain both emotionally and cognitively organized in the advent of high arousal. They also tend to be more exclusively loss-oriented, displaying more chronic forms of grieving inhibiting them from emotional alleviation in times of distress (Strobe, 2002).

Ambivalence and anger towards the parent and/or stranger on part of the insecurely attached child plays out prevalently throughout life for this population (Cassidy & Berlin, 1994).

Children with insecure attachment styles find themselves frequently isolated among peer groups with lower frequencies of mutual or deep friendships (American Psychiatric Association, 2000). A study consisting of 5-7 year olds with insecure attachment reported that this population felt a sense of loneliness most frequently (Cassidy & Berlin, 1994). This population has also been noted to have lower levels of empathy towards others along with emotional vulnerability known to interfere with romantic relationships. These characteristics make insecurely attached children more susceptible to personality disorders attributing to higher risks of cutting or burning themselves, and ultimately dissociation in early adulthood (Sroufe, 2005).

#### *Legacy of Insecure Attachments in Adulthood*

Adults who grow up as children in household settings promoting insecure attachment show a restricted range of emotion. When confronted by distress they tend not to be conscious of their feelings and have greater difficulty sharing them with others (Cassidy, 1994). They tend to cut themselves off emotionally and become ill-equipped to regulate and sooth during periods of distress. This decreased distress tolerance not only increases levels of anxiety but also diminishes emotional availability towards others close to them such as relationship partners and their children (Peck, 2003).

Unlike securely attached individuals who can regulate their emotions during times of distress, insecurely attached people find themselves continuously monitoring their own bewildering emotions. Self-regulation provides securely attached people with the ability to provide more emotional empathy towards others while restricting those with insecure attachment from engaging in these same activities. The literature shows that

insecurely attached people tend to become vicariously aroused either with discomfort or anxiety through others' distress and thus cannot focus on their needs or worries (Peck, 2003).

Lower levels of empathy experienced among people with insecure attachment lead to difficulties establishing romantic relationships that are long lasting. A study by Hazan & Shaver (1987) concluded that relationships consisting of people with insecure attachment styles lasted 10.02 years on average; while those with avoidant and ambivalent attachment styles lasted 5.97 and 4.86 respectively. Romantic relationship experiences also differed dramatically. Those consisting of securely attached individuals reported experiencing their relationships as friendly, happy, and trusting. Experiences derived from those with avoidant attachment styles, on the other hand, tended to be marked with fears of closeness; while ambivalently attached people experienced jealousy, emotional highs and lows, and strong desires for reciprocation (Hazan & Shaver, 1987).

Anxiety symptoms derived from insecurity not only play out in fear and avoidance of romantic relationships but also throughout the childrearing phases in life. It is often experienced as disorganization by parents and can be a predictor of intrusiveness or maltreatment towards their children. This abuse can be experienced either physically and/or mentally (Main & Hesse, 1990). It can be performed either intentionally or inadvertently on the caregiver's part and experienced in a very benign manner.

For example, studies have found that mothers with insecure attachment styles tend to respond with more promptness and greater frequency to expressed fears from their babies and have little reaction to their happier states. This reduces the infant's

exploration and causes him to stay in closer proximity to his mother. Other studies show mothers interacting with their children by directing the conversation towards their own emotions and reflecting an inability to function autonomously. These studies have noted that such behaviors promote insecure attachments among growing children in later years (Cassidy & Berlin, 1994).

The review of literature suggests that insecurely attached parents utilize intrusiveness and maltreatment towards their children in a strong attempt to continue their need for reassurance within the relational dyad. Ainsworth (1978) noted that an insecurely attached mother would assure her importance to the infant by only providing intermittent responses to the child, thus making the infant dependent on her and most likely to increase its attentions towards her. Consistent responses at proper times would decrease the child's dependency towards the mother and her attachment needs would not be met.

Cassidy and Berlin (1994) further note other means by which insecurely attached parents increase physical and emotional proximity with their child by becoming incompetent as caregivers. The parent's incompetence as a provider in effect worries the child and elicits caregiving behaviors towards the parent. The child then monitors the parent for two reasons: First, to ensure her safety and well-being, and second, to ensure their attachment base which is recognized as volatile by the child. The child fears that if the mother is gone then it will be unable to explore and might become incompetent itself.

Children of insecurely attached parents not only experience parentified roles in their relationship with their parents but also begin to recognize preferred behavioral patterns. They receive rewards from the parents which in this case would be proximity



with their secure base. These behaviorally trained emotional patterns encourage the child to take on more avoidant roles which then lead to a continued intergenerational legacy of insecure attachment within the family (Cassidy & Berlin, 1994).

## CHAPTER III

### METHODOLOGY

A substantive body of literature has accrued about the high incidence of attachment insecurity among children reared by schizophrenic mothers. Most of this literature has been quantitative and based on the practice wisdom of clinical practitioners that have worked with the mother and/or family in treatment. The primary emphasis in this body of work has tended to be on the problems schizophrenic mothers experience in their attachments to their children that result in their children having insecure attachments. Very little attention has been paid to the subjective experience of the child. This qualitative study was designed to explore what we can learn from the practice wisdom of clinical practitioners about the subjective experience of the child that has been raised in a family where the primary caretaker is a mother that had been formally diagnosed as schizophrenic. How does the child come to know and make sense of their relationship with the mother; and what strategies such children develop, that may or may not be adaptive, to adjust to their mother's attachment?

#### *Characteristics of participants*

The criteria for participation in this study was that subjects be licensed clinical practitioners, who self-identified as having engaged in clinical work with children that had grown up in a household where the primary caretaker was a mother that had been formally diagnosed as schizophrenic. The actual clinical work with the client(s) may

have been during childhood or with the child as an adult. All participants must have treated a minimum of three such cases.

#### *The Recruitment Process and the Nature of Participation for Subjects*

Participants were recruited utilizing a snowball sampling strategy beginning with referrals at my current placement. Once someone was identified as a potential candidate they were contacted by phone and invited to participate and/or recommend other potential participants. Those who consented to participate were seen in a face to face interview that took approximately one hour. The interview was scheduled at a time and place that was convenient for both the subject and the researcher. For their information, each participant was mailed a copy of the informed consent that they were required to sign at the time of the interview prior to the interview.

At the beginning of the face to face interview participants had an opportunity to ask any remaining questions before signing two copies of the informed consent which the researcher provided. The researcher kept one signed copy of the informed consent and gave the other to the participant for their records. The format of the interview included a pre-established schedule of structured demographic questions and semi-structured open-ended questions that probed participants' practice wisdom. The interview was audio taped and this researcher took some additional notes during the interview.

#### *Potential Risks and Benefits for Subjects*

There were few potential risks to participation in this study. However in any experience of self-reflection there is always the possibility that strong feelings may

emerge which the participant may feel requires further attention. The informed consent advised participants of this potential risk.

There were no financial benefits to participate in this study. Participants may have received personal satisfaction in knowing that they were contributing to improving service delivery to children growing up in families where the primary caretaker is a mother that had been formally diagnosed as schizophrenic by expanding our knowledge base about the subjective experience of the child. They may have also welcomed the opportunity to reflect on their practice wisdom.

#### *Informed Consent Procedure*

A copy of the informed consent was mailed to participants for their information prior to the face-to-face interview. At the time of the interview participants were given the opportunity to ask any remaining questions they might have had about the study before signing two copies of the informed consent, one for the researcher's records and the other for the participant's records. All participants were reminded of their right to not have to answer any question(s), as well as their right to withdraw from the study for any reason and with no penalty of any kind until May 1, 2008, when the study was to be written up. Participants were informed that if they chose to withdraw, all materials associated with their participation in the study would be destroyed.

#### *Precautions Taken to Safeguard Confidentiality and Identifiable Information*

The researcher advised subjects not to use names or identifying information when talking about any cases in order to protect clients' confidentiality. Furthermore, the researcher maintained privacy and confidentiality by removing all subject names from

interview tapes and transcripts and assigning numeric codes to these materials. Information collected during the study was reported in the aggregate only. Any illustrations or brief quotations included in the study were sufficiently disguised so as to prevent identification of specific subjects. The researcher kept and will continue to keep interview tapes and transcripts in a secure place for three years in accordance with federal regulations. Tapes and transcripts will remain secured until no longer needed when they will be destroyed.

## CHAPTER IV

### FINDINGS

#### *Demographic Background of Participants*

The sample was comprised of eight clinical practitioners, ranging in ages from 30-64 years old, with a mean age of 49 years old. Five (5 = 62.5%) participants were females, while three (3 = 37.5%) were males. Five identified as Caucasian (5 = 62.5%), two as Hispanic (2 = 25%), and one as Asian (1 = 12.5%).

Table 1

#### *Participant Demographic Background: Personal Information*

<b>Participant</b>	<b>Age</b>	<b>Gender</b>	<b>Race/Ethnicity</b>
<b>1</b>	30	Female	Hispanic
<b>2</b>	34	Male	Asian
<b>3</b>	41	Female	Caucasian
<b>4</b>	46	Male	Caucasian
<b>5</b>	54	Female	Caucasian
<b>6</b>	58	Male	Caucasian
<b>7</b>	62	Female	Hispanic & Jewish
<b>8</b>	64	Female	Caucasian

Overall, this was a seasoned group of practitioners. All were licensed in their disciplines. Three (3 = 37.5%) held a Master's in Social Work degree, two (2 = 25%) held a Philosophy Doctorate (Ph. D.) in Psychology degree, two (2 = 25%) held a

Medical Doctor (M. D.) degree, and one (1 = 12.5 %) held a Doctor of Osteopathic Medicine (D.O.) degree. The number of years licensed ranged from 2-34 with a mean of 14.75. The number of years in direct clinical practice ranged from 6-25 with a mean of 15. (See table 1 and 2.)

Table 2

*Participant Demographic Background: Professional Information*

<b>Participant</b>	<b>Professional Degree</b>	<b>Years in Direct Clinical Practice</b>	<b>Years Licensed</b>
<b>1</b>	MSW	6	3
<b>2</b>	DO	6	5
<b>3</b>	PhD	8	5
<b>4</b>	MD	16	20
<b>5</b>	MSW	30	26
<b>6</b>	MD	19	34
<b>7</b>	PhD	25	23
<b>8</b>	MSW	11	2

The majority (5 = 62.5%) had experience working both inpatient and outpatient settings. Of the remaining three participants, two (2= 25%) had only outpatient and one (1 = 12.5%) had only inpatient experience. At the time of the study only one (1 = 11%) participant was working exclusively in private practice.

Table 3

*Participant Demographic Background: Types of Settings*

<b>Participant</b>	<b>Number of Years Inpatient</b>	<b>Number of Years Outpatient</b>	<b>Number of Years Private Practice</b>	<b>* Number of Relevant Cases</b>
<b>1</b>	--	6.5	--	A
<b>2</b>	3	6	1	B
<b>3</b>	5	3	--	B
<b>4</b>	16	--	--	C
<b>5</b>	15	15	--	A
<b>6</b>	5	8	6	C
<b>7</b>	--	7	22	A
<b>8</b>	10	1	3	C
<b>Total:</b>	54	46.5	32	--
<b>Mean:</b>	6.75	5.8125	4	--

\* Note: A = 3-6 cases; B = 7-10 cases; C = 10+ cases

Of the eight participants, five (5 = 62.5%) had both inpatient and outpatient experience. Of the remaining three participants, two (2 = 25%) had outpatient experience alone while one (1 = 12.5%) had only inpatient experience. In terms of private practice, four (4 = 50%) had experience with private practice and four (4 = 50%) did not. The majority of participants (5 = 62.5%) had treated more than seven cases that met the criteria for the study. (Please refer to table 3.)

*Qualitative Questions*

After the demographic questionnaire portion of the interview was completed, participants were asked to select a case that stood out for them where they were working with a child who grew up in a family setting where the primary caregiver was a mother



who was formally diagnosed as schizophrenic. Participants were told that the actual work with the clients could have been during childhood or as adults. Although there were only 8 participants this question generated 9 cases and 10 children for discussion. One participant (1 = 12.5%) discussed a case consisting of two children in the same family and one other participant (1 = 12.5%) discussed two separate cases with different individuals.

#### *Demographic Background of Clients Discussed*

Ten clients total were the primary focus of the sample participants throughout this study. It should be noted that participants 3 and 5 discussed family cases but identified only one client as the primary focus of discussion. Also, participant 4 discussed a family case where he was treating the mother, but recollected close clinical interactions with her daughter.

At the time of treatment, the ages of clients discussed ranged from 12-42 years old, with a mean age of 22.7 years old. This was a bimodal population. Half (5 = 50%) were in adolescence and ranged in age from 12-18 years old; and half (5 = 50%) were in early to mid-adulthood and ranged in age from 22-42 years old. All of the adolescent cases involved foster care. Of the five clients in adulthood, two (2 = 20%) lived alone, two (2 = 20%) lived with their families, and one (1 = 10%) was homeless.

No client discussed (0 = 0%) held employment. In terms of education, four (4 = 40%) clients were in high school, two (2 = 20%) in middle school, two (2 = 20%) were college graduates, one (1 = 10%) was unemployed, and the remaining (1 = 10%) was unclear as to their level of school completion.

Six (6 = 60%) clients were male, while four (4 = 40%) were female. Four (4 = 40%) were identified as Hispanic, three (3 = 30%) as African-American, two (2 = 20%) as Caucasian, and one (1 = 10%) as mixed with Hispanic and Caucasian.

Out of the ten mothers discussed in each case, eight (8 = 80%) were diagnosed with paranoid schizophrenia and two (2 = 20%) with schizoaffective disorder, bi-polar type. In contrast only two (2 = 20%) of the ten children discussed were diagnosed with chronic mental disorders. One was diagnosed with schizoaffective disorder, bi-polar type, while the other was diagnosed with major depressive disorder, recurrent type. Among the remaining eight children, three (3 = 30%) were diagnosed with both anxiety and depression disorders, two (2 = 20%) with anxiety disorder not otherwise specified. One (1 = 10%) who was 13 years old was diagnosed with post traumatic stress disorder, and one with mild depressive disorder.

In terms of treatment modalities, only individual and family therapies were used as interventions. Six clients (6 = 60%) were treated with individual therapy alone, while four (4 = 40%) with both family and individual interventions. There were no cases treated exclusively with family therapy alone.

Table 4

*Demographic Background of Client Discussed*

<b>Participant</b>	<b>Age during time of Tx</b>	<b>Gender</b>	<b>Race / Ethnicity</b>
<b>1</b>	12	Male	Hispanic
<b>2</b>	22	Female	Caucasian
<b>3</b>	13	Male	African-American
<b>4</b>	15	Female	Hispanic
<b>5</b>	24	Female	Mixed (Caucasian & Hispanic)
<b>6</b>	40	Female	Caucasian
<b>7a</b>	17	Male	Hispanic
<b>b</b>	18	Male	Hispanic
<b>8a</b>	24	Male	African-American
<b>b</b>	42	Male	African-American

Table 4

*Demographic Background of Client Discussed (Continued)*

<b>Participant</b>	<b>Age during time of Tx</b>	<b>Education</b>	<b>Living Arrangement During Time of Tx</b>
<b>1</b>	12	Middle School	Foster Home
<b>2</b>	22	College Graduate	Alone
<b>3</b>	13	Middle School	Foster Home
<b>4</b>	15	High School	Foster Home
<b>5</b>	24	Graduate Student	Family
<b>6</b>	40	Not Specified	Alone
<b>7a</b>	17	High School	Foster Home
<b>b</b>	18	High School	Foster Home
<b>8a</b>	24	High School	Homeless
<b>b</b>	42	Unemployed	Family

Table 4

*Demographic Background of Client Discussed (Continued)*

<b>Participant</b>	<b>Age during time of Tx</b>	<b>Case Diagnoses for Client's Mother</b>	<b>Case Diagnoses for Client</b>	<b>Type of Case Contact</b>
<b>1</b>	12	Paranoid Schizophrenia	Mixed (Anxiety/Depression)	Family & Individual
<b>2</b>	22	Schizoaffective (Bipolar)	Anxiety Disorder NOS	Individual
<b>3</b>	13	Paranoid Schizophrenia	Post Traumatic Stress	Family & Individual
<b>4</b>	15	Paranoid Schizophrenia	Anxiety Disorder NOS	Family & Individual
<b>5</b>	24	Paranoid Schizophrenia	Post Traumatic Stress, Anxiety Disorder NOS	Individual
<b>6</b>	40	Paranoid Schizophrenia	Major Depression-Recurrent	Individual
<b>7a</b>	17	Paranoid Schizophrenia	Mild Depression	Individual
<b>b</b>	18	Paranoid Schizophrenia	Post Traumatic Stress	
<b>8a</b>	24	Paranoid Schizophrenia	Prodromal Schizophrenia	Individual
<b>b</b>	42	Schizoaffective (Bipolar)	Schizoaffective (Bipolar)	Individual

### *Overview of Cases Discussed*

Participants were asked to select and discuss an outstanding case that stood out for them where they had worked with a child who grew up in a family setting where the primary caretaker was a mother who was formally diagnosed as schizophrenic. In terms of the nine cases generated, all depicted (9 = 100%) chaotic households. Violence was a feature in all cases (9 = 100%), whether the violence was directed towards the child (5 = 56%), or whether the violence was between other members in the household with the child as an observer.

In eight of the nine cases (8 = 89%) the respondents explicitly noted multiple hospitalizations of the mother. In the one remaining case (1 = 11%) multiple hospitalizations or absences were implied (e.g. multiple foster home placements) although not explicitly stated. Similarly in eight cases (8 = 89%) the respondents explicitly noted that the mother was unable to physically care for the client. In the one remaining case (1 = 11%) it was implied (e.g. multiple hospitalizations of mother and neglect of child care by father).

Fathers were overwhelmingly (8 = 89%) absent in these households. Mothers also tended (6 = 67%) to be non-compliant with their medication. Of the nine cases, six (6 = 67%) described children as being parentified. While mothers were the primary caretakers, the majority (6 = 67%) tended to be non-compliant with their medications and their children were parentified. In approximately half of the households (5 = 56%) represented by these cases at least one family member abused drugs and/or alcohol. In approximately half of the households (4 = 44%) there had been periods of homelessness. In three cases (3 = 33%) siblings had multiple fathers. In two instances, one (1 = 11%)

described a mother accidentally overdosing on her medications and dying, while the other (1 = 11%) described a son physically abusing his mother.

In summary, parental figures were absent or intermittently available and children were parentified.

Participant 1:

This was a 12 year old boy...born in Mexico....Mom...was diagnosed with schizophrenia when...she (the mother) was...35... [She had] two other children...a one and a half year old [boy and a nine year old girl]...When [the mother] had her last child, she was hospitalized because...her symptoms got so severe and she wasn't on medications...The mom was having a lot of delusions that she was...the devil and she had plans and intents to kill the children...And the dad was not supposed to leave the children alone. And he did. And that was reported and so...DCFS, Department of Children and Family Services, came in and removed the children and then the children came into our clinic.

Participant 2:

The [client] grew up solely with the mom...who had schizoaffective disorder, bipolar type and had been in and out of hospitals her entire life developing the illness shortly [after] she had current pregnancy with her daughter (i.e. the client)...When she developed or when her illness got worse she would become hyper-religious and very paranoid that people were after them; that helicopters were following them, that the air was being poisoned. The mom organized herself around the daughter.

Participant 3:

There were 3 siblings....that I had once in foster care...the one that stood out the most would be the boy who was age 13. He....was sexually abused, physically abused, emotionally abused....and....according to his report...it seems like it was due to his mother's [psychotic] break, her illness....[This] was a very chaotic home... He and his half-siblings at the time....were kept home from school for a period of about 2 months. Their mother would not allow them to bathe or leave the house. She shaved all of their heads and threw them outside at night in the cold. This was December! Naked!

Participant 4:

[The] mom who...about 35 years old with a diagnosis of schizophrenia...was frequently non-compliant with her medication. .... Unfortunately every time that she became non-compliant, she...got delusional, [experienced] hallucinations,

[was] unable to make good judgments...so what would happen is...the [client's] mom would contact me and tell me that her daughter was not doing well that the 4 children that she had that ranged in ages from 15 down to 2...were all being kind of neglected, they weren't being taken care of. There was no dad in the picture...[The four children] were from 3 different fathers. None of them were taking responsibility so...things would get bad...The grandma I guess...would...get involved for taking over the kids and then I had to get involved in terms of hospitalizing [her]...Eventually...once you get hospitalized, the department of children and family services would get involved.

#### Participant 5:

[This] young woman who was probably at the time 24...was a medical student at the (omitted) medical school...She had been with her mother in psychiatric hospitals for admission since she was a little girl. And she was really suffering practically from PTSD...traumatized from very young in ways that were very vivid as she described them...Her mother would have delusional episodes. She would definitely hear voices. And she would want the kids to hear them so sometimes this girl would say she heard the voices so that the mother would feel less frustrated and traumatized. So she (the client) actually was invested in the delusion. Colluding in the delusion to keep her mother from feeling worked up. That made her (the client) feel nuts....

#### Participant 6:

The mother developed schizophrenia probably in her (the client) late 20s early 30s...Her mother was only invariably there. When her mother was taking her medications and doing well she (the client) felt that she (her mother) was a good mother. There were other times—and she couldn't predict when the mother had auditory hallucinations—that...she felt her mother clearly wasn't there...One time her mother chased her and her brother out of the house with a knife thinking that they were demons and they were out to get her...[The] mother had been hospitalized numerous times and had been on numerous psychiatric medications...The mother actually overdosed probably accidental on her medications and died when the [client] was...mid-30s....

#### Participant 7:

[Two] children were removed from the mother's custody due to [her] diagnosis (paranoid schizophrenia)...And the children were placed in foster care. There were no visitations because we didn't know where the mother was...The parent [was] homeless and [the children] didn't know where she was at... I'm aware that there was a previous time when the mother was following the treatment and there were contacts between the mother and the children...But there were many relapses and numerous hospitalizations...



Participant 8:

Case 1:

We were evaluating [this client] for prodromal schizophrenia...There a great deal of denial on his evaluation because he was so fearful of having any symptoms that might be anything like his mother...As he (the client) got older and entered adolescence and ....[his mother] became more sick...She was hospitalized many times...There was estrangement...There was an adversarial angry relationship.

Case 2:

We had a 42 year old African-American who came in.... He was schizoaffective, bipolar type...[Currently] living with mother who is schizophrenic...[The mother] was 86 and now no longer able to move because of arthritis very much. They were both frequently hospitalized. He wouldn't cook for her. He was at times; potentially threatening to her...We with his case... were able to bring in case management in what was called a full service partnership...because there were financial things in place as apposed to the first. It would help him get an apartment and then I ended calling home supportive serviced and adult protective serviced because he had threatened her and potentially violent.

Table 5

*Overview of Cases Discussed*

<b>Participant:</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>*7a</b>	<b>*7b</b>	<b>8a</b>	<b>8b</b>	<b>Total:</b>
Violence in the household	X	X	X	X	X	X	X	X	X	X	<b>10</b>
Multiple hospitalizations of mother	X	X		X	X	X	X	X	X	X	<b>9</b>
Mother unable to physically care for client	X	X	X	X	X		X	X	X	X	<b>9</b>
Father(s) absent		X	X	X	X		X	X	X	X	<b>8</b>
Mother not medication compliant	X			X	X		X	X	X	X	<b>7</b>
Parentified Child	X	X			X		X	X		X	<b>6</b>
Foster care	X		X		X		X	X	X		<b>6</b>
Alcohol and substance abuse present	X		X	X					X	X	<b>5</b>
Physical/ sexual abuse of client	X		X				X	X		X	<b>5</b>
Homelessness					X		X	X	X		<b>4</b>
Siblings with multiple fathers			X	X	X						<b>3</b>
Mother overdosed and died						X					<b>1</b>
Client physically abused mother										X	<b>1</b>
<b>Total:</b>	<b>8</b>	<b>5</b>	<b>7</b>	<b>7</b>	<b>9</b>	<b>3</b>	<b>9</b>	<b>9</b>	<b>8</b>	<b>8</b>	<b>--</b>

\* Note: Participant presented one case with two client

### *Parentification of Child*

As noted approximately half of the clients (6 = 60%) presented were parentified in these chaotic households.

#### Participant 2:

Growing up...when it was just her and her mom she was responsible to make sure that her mom stayed well. Mom became ill. She was the one to take mom to the hospital. The mom when she was ill was only responsible for the bills and her cooking. So they broke it up that way. She (the client) would serve for reality testing for mom. Except sometimes she herself would become very paranoid because when your mom is always asking “You sure there is no one looking as us, you sure?” You start thinking that people are looking at you.

#### Participant 5:

She (the client) took on that care giving role...She was really well put together, but the thing was the pressure of medical school really was the final act that she couldn't keep it all together. She couldn't keep her mother going. Her siblings going. I mean even in medical school, she was bringing her high school age sister to get some [mental health] care.

#### Participant 6:

So he (the 12 year old client) would take care of his little sister. And then when the little baby brother was born he was in charge of changing the diapers, making sure there was food in the house and stuff like that.... Mom was completely unable to care for them and so that was his role. Even now, they're placed with tan aunt and he sometimes has difficulties just letting the aunt take the role of the caretaker.

### *How Children Made Sense of their Relationship with their Mother*

In all cases (9 = 100%) these children clearly perceived that something was wrong with their mothers that resulted in their being unpredictable and unreliable as caretakers. The children conveyed this to their therapists in two different ways. Sometimes they spoke of their mother as being “sick,” “crazy,” or “bizarre.” At other times they spoke of her being “damaged” or “broken” with the implicit notion that she needed to be fixed.

Participant 1:

There was a point where he (the client) no longer...related to mom other than “she’s sick.”...It just seemed like...“mom is not stable.” “She’s unpredictable.” He (the client) [did not] know when she (the mother) [was] gonna be okay... It [was] just scary not knowing when mom [was] gonna be well.

Participant 2:

She (the client) says...her “Mom’s crazy!!!”...While she says her mom is “crazy” she describes all this stuff her mom does. It...causes a lot of anxiety for the daughter because she feels helpless...The mom has a lot of medical complications and refuses to get medical care ...The mom is the only real stable object that the daughter has ever had and the daughter is terrified that she’s gonna lose her.

Participant 3:

...He (the client) could not trust her (the mother). [He was] terrified of her...He did recall some happy times with her back when she used to cook but also—it would come up...She was very abusive...They used to sit at the kitchen table and do their homework and if he didn’t get something right, she would just flip out and basically hit him...So he saw her as very angry...broken...He simply couldn’t make sense of what it was...[The client] saw her as broken and damaged because how could she do all these wild and bizarre things and still be his mom?

Participant 4:

[The patient] saw [her] mom as someone who was damaged in some way. That didn’t deserve the level of respect that a mom normally does and was treated, if anything, as...a wayward sister. The one who every so often went off the deep end and you had to kind of bring them back.

Participant 5:

She just saw her mother as kind of a weak, sick, loving woman who needed a lot of help...She idealized her mother to some degree...She loved her mom and...She knew her mom was just incapable.

*Strategies the Child Developed to Cope*

It is to be noted that all participants had difficulty responding to the question of what strategies children developed to cope with their mother’s illness. Approximately half (4= 44%) gave no response or could not identify any strategies at all. The remaining

five (5 = 56%) respondents collectively generated three strategies: dissociation/ detachment, hyper-vigilance and projection. It should be further noted that all of the respondents that were able to identify strategies that these children developed to cope with their mother's illness considered these strategies to be adaptive. At the same time they were aware that these same strategies may hinder relationships outside the family over the course of the life cycle.

Participant 1:

[The client] wanted to take care of somebody and was hyper vigilant or hypersensitive to the needs of the mother and others...He [also] had that sense...of detachment (towards his parent). Like he couldn't...count on [his father and mother].

Participant 5:

She created a "false self" really early on so that she could be her mother's nurturer. And it really helped her not hate her mother...So a lot of the pain and suffering that she would've felt, she didn't disclose because I think she really walled it off...she had walled off a great deal...She could not extricate herself from her mother...If she were able to be even more disappointed, more angry, more fed up, just more burned out, she might have been able to have gotten a little more distance from the situation, but it was really strange just how symbiotic she still was with her mom to the very end when I saw her.

Participant 7:

[The clients] went to school and pretend[ed] to be normal despite knowing their mother's illness... They dissociated from their home situation but [they had] an idea of what a normal home was because they got it from T.V., and they got it from movies, and their peers in school. They were fearful people would find out about them being different.

Table 6

*Strategies the Child Developed to Cope*

<b>Participant:</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7a</b>	<b>7b</b>	<b>8a</b>	<b>8b</b>	<b>Total:</b>
Dissociation/ Detachment	X				X		X	X			<b>4</b>
Hyper-vigilance	X		X								<b>2</b>
Projection		X	X								<b>2</b>
<b>Total:</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>--</b>

*Range of Emotions from Being Raised by the Mother*

All of the respondents (9 = 100%) spontaneously spoke of the intense affect generated by the inconsistent caretaking of their mothers. This group generated five affects in this category: estrangement, fear, anger, guilt and confusion. By estrangement respondents seemed to be describing a hostile, unsympathetic indifference to the mother. The emotions of fear, anger and confusion were associated with the tremendous uncertainty of not knowing when and how long the mother would be available to them; and when they would have to deal with her loss. The guilt could be about any of these emotions.

Participant 4:

The 15 year old, I'd say had a lot of resentment and anger towards her mom. She didn't like the fact that her mom would get crazy sometimes and wouldn't be able to do things...She just didn't like the fact that she was bouncing back and forth...She didn't like the fact that mom would disappear for months at a time—really not disappear, but go to the hospital.

Participant 5:

She (the client) really felt, I think, in part guilty when her mother would have a relapse. Sometimes it was common that she felt that “my magical powers are

about keeping everything afloat, I could've done more!" She kept doing more. She never gave up on her mom, really. And I think a lot of what did have to do with this was the fact that she was the oldest. I don't know exactly how she had incorporated the meaning of [the fact] that every time her mother had another child, her mother seemed to get sicker and stay sicker and longer. She may have had a part of her believe that her pregnancy...her being on this earth may have created her mother's first illness.

Participant 6:

She (the client) felt that the mother wasn't available and didn't feel very close to her mother. She felt bad for her mother and she wanted to take care of her mother but she didn't feel that her mother was there for her...She hated...the situation and the unknown...She would be angry at her mother...Not knowing the way her mother was going to be from week to week or from month to month...The patient felt a sense of estrangement.

Participant 7:

There was guilt on the part of the children...They thought they fail[ed] as a parentified child. [They] failed to protect... [They] didn't understand why a person that was taking pills didn't get better...The children [had] a difficult time understanding chronic disease treatments that fail...

Participant 8:

In both cases [there was a] repeated...cycle of feeling abandoned and the estrangement would increase (on the client's part). [They] didn't want to talk to her...The dynamic was, "Well she's not gonna come forward [for me] anyway."

Table 7

*Range of Emotions from Being Raised by Schizophrenic Mother*

<b>Participant:</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7a</b>	<b>7b</b>	<b>8a</b>	<b>8b</b>	<b>Total:</b>
Estrangement			X	X	X	X	X	X	X	X	<b>8</b>
Fear	X	X	X								<b>3</b>
Anger				X	X	X					<b>3</b>
Guilt					X		X	X			<b>3</b>
Confusion			X								<b>1</b>
<b>Total:</b>	<b>1</b>	<b>1</b>	<b>3</b>	<b>2</b>	<b>3</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>--</b>

### *Knowledge and Understanding of Mother's Schizophrenia*

As indicated in all cases (9 = 100%) clients knew that something was wrong with their mother. However, they did not seem to grapple with their mother's formal diagnoses of schizophrenia until they were in adolescence. In all of these cases respondents suggested that their clients struggled with understanding schizophrenia as a chronic and relapsing illness with the implicit idea that the mother could not control her odd behaviors.

#### Participant 1:

I think he didn't know his mom had a mental illness...because I asked him...“Do you know what's wrong? What's going on with your mom?” And he just said, “No”...So we spent some time talking about it. And I think maybe he understands a little but again it's...such a...complex [thing] to understand. Like “You're mom thinks she's the devil because there's a chemical imbalance and it's not really true but...” I don't know how much more of an understanding he has. But I think at least it's talked about.

#### Participant 2:

...her earliest memories [at age 5 years old] were inside the clinic from what she could remember...So she grew up with this. This was her life. She didn't know anything different. She described learning [about the illness] as she learned the way the clinic was structured...She described to me that for most of her life...she thought [one particular] room was where all the crazy people were...Maybe in mid-high school she realized that that's where the clinicians were (laughs).

#### Participant 3:

He didn't know [what was going on at first]...” Mom's cutting little roses while god's talking to her.” He found that pretty normal. He didn't know that was really uncommon. Although after our work he did. [Afterwards] he saw that she was sick even though he didn't know what it was...He didn't understand that it was a long term illness.

[But] there was still the fantasy, that magical thinking about “mom's gonna get better and I can go back home and everything's gonna be okay or...that somehow it will get fixed.” But at the same time he also had the confusion of “well, she won't take the medicine” and so he kinda knew that that was an integral part of her symptoms going away.



Participant 4:

She (the client) knew very well what the schizophrenic diagnosis was. She'd been described to her by her mom—number one—and by me directly—number two. She (the client) understood exactly what it meant in terms of what these symptoms were because she would be able to recognize them early on (approximately age 8 or 9 years of age) and call her grandmother and tell her “its coming back.”

Participant 5:

She (the client) talked about her mother as though she always knew her mother was crazy. To her memory, she did not talk about it ever having had a memory of her mother not crazy.

Participant 6:

The child knew that the mother had a mental illness. She knew that the term was schizophrenia. But other than that, thought that mother could control it and it was her mother's fault. So [the term] didn't mean anything...she knew [the diagnosis] by words because people told her but no way did she really understand it. And nobody told her [anything further]. Father didn't tell her. Doctors didn't tell her. Nobody told her. It was just kind of “mom's weird.”

Participant 7:

I think they knew that the parent had a mental illness...I think their understanding went back and forth...But different according to the child. I don't think they understood the chronicity and that it's not curable...I don't think they understood that it was permanent all of the time at least. They knew that it was weird. They knew that it was odd behavior. And they knew that they were odd thoughts.

Participant 8:

[For both cases] I think by the time they [were] adolescents. They had some idea of the name of the illness...

*How Learning about Schizophrenia as an Illness Impacted the Child's Relationship with the Mother*

This was another question participants had difficulty answering. Four (4 = 44%) participants gave no response to this question. Two participants (2 = 22%) noted that understanding schizophrenia as an illness helped clarify confusion about their client's

mother's behaviors. In two cases (2 = 22%) the child experienced shame, humiliation, and anger towards the mother after gaining knowledge of the formal diagnosis. In one case the child was better able to help her mother after better understanding the implications of the formal diagnosis of schizophrenia. In one case (participant 3) learning about the formal diagnosis of schizophrenia increased his confusion about his mother's illness/ behaviors.

Participant 1:

Understanding the mother's illness probably ease[d] a lot of the confusion [for the client]...It helped him make sense more. "Okay, so mom was acting like this...maybe she's acting like this not because I did something but because there's something in her."...So I think...it made it normal...it made it okay..."There's a reason why my mom is acting like this. It has nothing to do with me...When somebody has schizophrenia, they hear voices. They believe things that aren't true."

Participant 3:

He (the client) was horrified, shocked, confused and just in utter disbelief like "What is this illness?" and "Why is it making her act this way?" "What are these things that she's doing?" And not being able to connect the symptoms really to the illness...So it was such a difficult thing that he just couldn't grasp—cognitively grasp it. Just, in such trauma, total trauma mode.

Participant 4:

After understanding what schizophrenia was the (the client) began to think about taking on the responsibility of identifying when [mother's] symptoms would come...She took responsibility..."I just can't leave. I gotta deal with this."

*Was Case Illustration a Typical Case?*

When asked how typical this case was of all cases treated working with children reared by schizophrenic mothers most respondent noted (6 = 67%) that what they described was an atypical case. According to these participants, these cases were atypical in one of two ways: either the symptomatology or environmental stressors on the client

was unusually dramatic or it was a case where they were more hopeful about a client who seemed to prevail in spite of the odds.

Participant 2:

This is a very different case. The vast majority of those...I've seen, if the parents have been identified as schizophrenic, the [clients] turn out to have a lot of the same traits...they're going down the same pathway. This was very different. This doesn't mean she's not gonna develop [schizophrenia] because her mom developed it when she was in her mid-30's (Client is currently in early 20's.) But I haven't seen somebody who is this driven to succeed...The big difference with her at this point is she has insight. She's trying to change.

Participant 3:

[This case was]...the most horrifying and difficult for me as a clinician because of the circumstances and the nature of the abuse.

Participant 4:

This one (case) stood out because this was a little different than other cases....The 15 year old stands out particularly because of her way of dealing with the situation. [She took on many more responsibilities than most adolescents.] So I wouldn't exactly say it wasn't typical.

Participant 8:

The second case is very a-typical...That's unusual for the family to still be that intact (after experiencing a mother who is psychotic). Most often the families are not intact at all and the estrangement and the anger is pretty typical.

The remaining three respondents (3 = 33%) felt that the cases they described were typical of all the cases they had treated.

Participant 1:

I think this case...is pretty typical...

Participant 6:

What I've described is a pretty typical situation. Not only with parents of schizophrenia but other parents that aren't available too—for whatever reason medical illnesses, substance abuse issues...dying is as little less dramatic but it

still has some of these components. It basically all goes to...something to do with secure attachment.

Participant 8:

The first case was the most typical... Simply because I've been the longest in the inpatient setting so I am more apt to see somebody who is dually diagnosed. They may have a major depressive component, a schizoaffective, or maybe a prodromal schizophrenia coming in with the parent with schizophrenia—the mother in this case—who are totally estranged or just some oddities.

Table 8

*Typicality of Case*

<b>Participant:</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7a</b>	<b>7b</b>	<b>8a</b>	<b>8b</b>	<b>Total:</b>
Atypical		X	X	X	X		X	X	X		<b>7</b>
Typical	X					X				X	<b>3</b>

*Other Significant Observations*

At the end of the interview participants were asked if there was anything else they would like to add about the subjective experience of attachment for children who grew up in households where the primary caretaker was a mother who has been formally diagnosed as schizophrenic. Six participants (6 = 67%) provided additional information. Three participants (3 = 33%) suggested that whatever the subjective experience of the child is, it is very powerful and it has ramifications for the child throughout his/her life cycle.

Participant 3:

There's lot of grief that kids raised by schizophrenic mothers are not able or near ready to get [close to]... They have to survive their childhood and only at that point can they...as an adult say "okay. I'm ready to deal with this."...So it's very sad stuff...Very sad stuff.

Participant 7:

The subjective experience [of the child] is very difficult... [It] is feeling that one is different and that not a lot of people are able to understand. And that there are certain thoughts “we’re going to keep secret,” through life maybe...It’s always risky to disclose them... [And] it has to do with [two] things: trusting others and...dealing with our own daemons by ourselves so that other people don’t judge us.

The remaining three participants (3 = 33%) emphasized the importance of having external supports to help the family cope with their mother’s illness.

Participant 4:

My experience is limited mostly to the Hispanic families where the damage might be somewhat limited because of this support network that’s created through maintaining some kind of family cohesion that might not be there in a traditional...family setting where its just mom and dad and a couple of kids. What’s unique about that population is how much the extended family is important. And I emphasize that because in the traditional Anglo-American family where you have sort of a much more autonomous situation: mom, dad, two kids...dog, car, garage, whatever...There’s not a lot of support for one person not able to carry their weight. And so what I’ve seen in Anglo families quite often is that when mom is sick, the mom gets hospitalized and things fall apart because there’s nobody there to be able to keep the things together.

Participant 5:

Looking at these three cases...the people who do better is that when “she (the mother) is not the only game in town”... I would also say that it’s a hard thing...to be the child of anybody...who is not able to help you formulate your view of reality...a mother and as somebody who has been a daughter I can’t imagine not being able to go to my parent....my mother, early in life and to not know that she was looking out for me. And what that does to a person.

## CHAPTER V

### DISCUSSION

The purpose of this qualitative study was to explore the subjective experience of attachment for children that have been raised in a family where the primary caretaker is a mother that has been formally diagnosed as schizophrenic. Most of this literature has been quantitative and based on the practice wisdom of clinical practitioners that have worked with the mother and/or family in treatment. The primary emphasis in this body of work has tended to be on the problems schizophrenic mothers experience in their attachments to their children that result in their children having insecure attachments. This qualitative study was designed to explore what we can learn from the practice wisdom of clinical practitioners about the subjective experience of the child that has been raised in a family where the primary caretaker is a mother that had been formally diagnosed as schizophrenic. How does the child come to know and make sense of their relationship with the mother; and what strategies do such children develop, that may or may not be adaptive, to adjust to their mother's attachment? The sample for this study was comprised of eight clinical practitioners that generated nine cases and ten children for discussion.

#### *Limitations*

This was a qualitative study that employed a sample of convenience. As such, the findings of this study cannot be generalized beyond this particular sample (Anastas,

1999; Padget, 1998). However, overall this was a seasoned group of practitioners. All were licensed in their disciplines with the mean number of years of experience of 14.75. Most participants had had both inpatient and outpatient experience. More important, the majority had treated seven cases that met the criteria for the study when the minimum was three. Thus respondents were above average informants. On the other hand, it should be noted that the majority also indicated that the case they selected to discuss was atypical in their practice.

It is also to be noted that respondents were clinical practitioners that were speaking retrospectively about their work. They were being asked to think about their work from the perspective of the child as subject when most often practitioners focused on the mother as subject and the child as object at the time of treatment. Thus it was sometimes difficult for the respondents to answer some questions. For example, four could not think of strategies that the child developed to deal with the mother's illness. Similarly, they struggled with identifying how learning about schizophrenia as an illness impacted the child's relationship with the mother. It is unclear whether some of this was due to how the questions were phrased or whether it was difficult for respondents to do this in retrospect since they had not originally conceptualized the case with the child as the subject.

### *Major Findings*

The major findings were:

1. In all cases (9 = 78%) the mothers had axis one diagnoses, the vast majority being diagnosed as paranoid schizophrenic.
2. In all cases (9 = 100%) the respondents described case situations where there were multiple hospitalizations of the mother.

3. In all cases (9 = 100%) the respondents described case situations where the children experienced neglect in their physical and emotional care.
4. In all cases (9 = 100%) violence was a feature whether the violence was directed towards the child, or was between other members in the household with the child as an observer.
5. In all cases (9 = 100%) the children clearly perceived that something was wrong with their mothers that resulted in their being unpredictable and unreliable as caretakers.
6. In all cases (9 = 100%) the mother's inconsistent caretaking generated intense negative affect (estrangement, fear, anger, guilt and confusion) in the child.
7. In all cases (9 = 100%) the child did not seem to grapple with their mother's formal diagnoses of schizophrenia until they were in adolescence, even though they might perceive something was wrong earlier.
8. In most cases (8 = 89%) the children also had axis one diagnoses.
9. In most cases (7 = 78%) the mother was head of a single parent headed household.
10. In most cases (6 = 67%) the mother was non-compliant with their medications.
11. In most cases (6 = 67%) the child discussed was parentified.
12. In most cases (6 = 67%) the case described was atypical in the respondents' clinical experience with this population. These cases were atypical because the respondent was more hopeful about the client described or the symptomatology and stressors on the client were unusually dramatic.
13. Half of the respondents (5 = 56%) were able to identify strategies that the child developed to cope with their mother's illness. They were dissociation/detachment, hyper-vigilance and projection.

All of the cases presented by the respondents were characterized by multiple hospitalizations of the mother, physical and emotional neglect of the child, and violence directed at the child or with the child as observer. In most instances the schizophrenic mother was a single parent and non-compliance with their medication was an issue.



While there is a face validity to these variables being interrelated, we have no way of knowing how typical this presentation is for children who grow up in households where the mother has been formally diagnosed with schizophrenia. As indicated we do not have good demographic data about this population. We don't know how large it is or what happens to the children.

In terms of diagnoses, it is significant to note that most of the mothers discussed were diagnosed as paranoid schizophrenic. On the other hand, while all of the children had axis one diagnosis, the diagnosis itself was much more variable. Specifically, only two had chronic mental disorders. The remaining eight had various combinations of anxiety, depression, and post traumatic stress disorder (PTSD). Again, we have no way of knowing how typical this presentation is of this population.

In terms of the actual question of how children make sense of their relationship with their mother, the findings from this sample suggest that children know something is wrong early on with the mother, that her inconsistent caretaking generates intense negative affect, and that they do not grapple with the mother's formal diagnosis of schizophrenia until adolescence. In a little more than half of the cases the child's experience was to be parentified.

In terms of strategies that the child developed to cope with the mother's illness, only five participants could respond to this question. Collectively they identified three strategies; interestingly these participants considered all of these strategies adaptive dissociation, hyper-vigilance and projection. As indicated some found it difficult to even answer this question. Again, we do not know how typical these strategies are for this population or whether there are more strategies to be identified.

### *Recommendations for Future Study*

The findings in this study point out the tremendous need for more information about this population. From a quantitative point of view, we know virtually nothing about the demographics of this population. This includes questions from how large it is to the various outcomes with or without treatment. From a more qualitative perspective it would be important to reproduce this study to see if these findings are sustained. Clearly, further refinement of the questions eliciting information about strategies these children develop to cope with their mother's illness would need to be addressed. It would also be important to investigate how these findings would stand up if respondents were asked to select a case that is more typical of their practice to discuss.

## References

- Ainsworth, M. D. S., Blehar, M.C., Wall, S. & Waters, E. (1978). Patterns of attachment. Hillsdale, New Jersey: Erlbaum.
- Ainsworth, M. D. S. (1979). Infant-mother attachment. *American Psychologist*, 34, 392-397.
- Allen, J. (2001). *Traumatic relationships and serious mental disorders*. New York: John Wiley & Sons.
- Allen, J. P. & Land, D. (1999). Attachment in adolescence. In J. Cassidy & P. R. Shaver (Eds.), *The handbook of attachment: Theory, research, and clinical applications*. (pp. 319-325, 330-331). New York and London, Guilford.
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders-Text Revision*. (4<sup>th</sup> ed.). Washington, D.C.: Author.
- Anastas, J. W. (1999). *Research design for social work and the human services (2<sup>nd</sup> ed.)*. New York: Columbia University Press.
- Apfel, R. J. & Handel, M. H. (1993). *Madness and loss of motherhood: Sexuality, reproduction and long-term mental illness*. Washington D. C.: American Psychiatric Press.
- Asarnow, R. F., Auerback, J. G., Hans, S. L., Marcus, J., Nuechternlein, K. H. & Styr B. (1999). Neurobehavioral deficits at adolescence in children at risk for schizophrenia: The Jerusalem infant development study. *Archives of General Psychiatry*, 56, 741-748.
- Belsky, J. (1999). Interactional and contextual determinants of attachment security. In J. Cassidy & P.R. Shaver (Eds.), *The handbook of attachment: Theory, research, and clinical applications* (pp. 249-264). New York: Guilford.
- Belsky, J., Cassidy J. (1994). Attachment and close relationships: An individual-difference perspective. *Psychological Inquiry*, 5(1), 27-30.
- Belsky, J., Rosenberg, K., & Crnic, K. (1995). The origins of attachment security: 'classical' and contextual determinants. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental, and clinical perspectives* (pp. 153-183). Hilldale, NJ: Analytic Press.
- Berlin, L. J. & Cassidy, J. (1994). The insecure/ambivalent pattern of attachment: Theory and research. *Child Development*, 65(4), 971-981.

- Berzoff, J, Laura, F.N., Hertz, P. (2002). *Inside out and outside in: Psychodynamic Theory and Practice in Contemporary Multicultural Contexts*. New York: Rowman & Littlefield Publishers, Inc.
- Brazelton T. B. & Cramer B. G. (1990). The earliest relationship: Parents, infants and the drama of early attachment. *Addison-Wesley*, xix-252.
- Bretherton, I., & Munholland, K. A. (1999). Internal working models in attachment relationships: A construct revisited. In (Eds.), J. Cassidy & P. R. Shaver, *Handbook of Attachment* (pp. 89-111). New York: Guilford.
- Brisch, Karl H. (2002). *Treating attachment disorders: From theory to therapy*. New York: Guilford.
- Bosanac, P., Buist, A., & Burrows, G. (2003). Motherhood and schizophrenic illnesses: A review of the literature. *Australian and New Zealand Journal of Psychiatry*, 37, 24-30.
- Bowlby, J. (1988). *A secure base*. New York: Basic Books.
- Cassidy & Berlin, L. (1994). The insecure/ambivalent pattern of attachment: Theory and research. *Child Development*, 65, 971-991.
- Cunningham, J., Harris, G., Vostanis, P., Oyebode, F., & Blisset, J. (2004). Children of mothers with mental illness: Attachment, emotional and behavioral problem. *Early Child Development and Care*, 174 (7-8), 639-650.
- Davies, D. (2004). *Child development: A practitioner's guide* (2<sup>nd</sup> ed.). New York: Guilford.
- Dellisch, H. (1989). Children of schizophrenic mothers. *European Journal of Child and Adolescent Psychiatry: Acta Paedopsychiatrica*, 52(4), 266.
- Dunn, B. (1993). Growing up with a psychotic mother: A retrospective study. *American Journal of Orthopsychiatry*, 63(2), 177-189.
- Emory, E., Walker, E. (1983). Infants at risk for psychopathology: Offspring of schizophrenic parents. *Child Development*, 54(5), 1269-1285.
- Flores, J. P. (2002). *Group therapy with addicted populations: An integration of 12 step- and psychodynamic theory*. New York: The Hathworth Press.
- Florian, V., Mikulincer, M., & Bucholtz, I. (1995). Effects of adult attachment style on the perception and search for social support. *Journal of Psychology*, 129, 665-676

- Flyckt L., Taube A., Edman, G., Jedenius E., Bejerkenstedt L. (1999) Clinical characteristics and insight in a group of severely ill schizophrenics. *Nord J Psychiatry* 53:377-382.
- George, C. & Salomon, J. (1999). Attachment and caregiving: The caregiving behavioral system. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment theory: Theory, research, and clinical implication* (pp. 649-670). New York: Guilford.
- Greenberg, J. R., & Mitchell, S. A. (1983). Margaret Mahler. In J. R. Greenberg & S. A. Mitchell (Eds.), *Object relations in psychoanalytic theory* (Ch 9). Cambridge, MA Harvard University Press.
- Hans, S. L., Auerbach, J. G., Styr, B. (2004). Offspring of parent with schizophrenia: Mental disorders during childhood and adolescence. *Schizophrenia Bulletin*, 30(2), 303-315.
- Harwood, R. L. (1992). The influence of culturally derived values on Anglo and Puerto Rican mothers' perceptions of attachment behavior. *Child Development*, 63(4), 822-839.
- Hatfield, B., Webster, J. & Mohamad, U. (1997). Psychiatric emergencies: Assessing parents of dependent children. *Psychiatric Bulletin*, 21, 19-22.
- Hearle, J., Hennifer, L., McGrath, J. J. (1999). The fertility and fecundity of patients with psychoses. *Acta Psychiatrica Scandinavica*, 99(6), 441-446.
- Hofer, M.A. (1995). Hidden regulators: Implications for anew understanding of attachment, separation, and loss. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental, and clinical perspectives* (pp. 203-230). New York: Academic Press.
- Immele, A., Smith, F. D., & McElhaney, K. B. (2006). Attachment organization as a moderator of the link between friendship quality and adolescent delinquency. *Attachment and Human Delinquency*, 8(1), 33-46.
- Jogeusen A, Teasdale T. W., Parnas F., Schulsinger H., Meduich S. A. (1987). The Copenhagen high-risk project. The diagnosis of maternal schizophrenia and its relationship to offspring diagnosis. *British Journal of Psychiatry*, 151, 753-757.
- Johnson, S. M. & Whiffen V. E., (2003) *Attachment process in couples and family therapy*. New York and London, Guilford. (Ch. 19, pp. 389-394).
- Kinniburgh, K. J., Blaustein, M. & Spinazzola, J. (2005). Attachment, self-regulation, and competency: A complex intervention framework for children with complex trauma. *Psychiatric Annals*, 35(5), 424-430.

- Kraemer, G. W. (1999). Psychobiology of early social attachments in Rhesus monkeys: Clinical applications. In C. S. Carter, I. I. Lederhendler, & B. Kirkpatrick (Eds.), *The integrative neurobiology of affiliation* (pp. 373-390). Cambridge, MA: MIT Press.
- Lemieux K. E., Muller, R.T. (2000). Social support: Attachment style as a mediator between abusive childhood experiences and adult relationship difficulties. *Journal of Child Psychology and Psychiatry*, 40(3), 465-477.
- Lyons-Ruth, K., & Jacobvitz D. (1999). Attachment disorganization: Unresolved loss, relational violence, and lapses in behavioral and attentional strategies. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 520-554). New York: Guilford.
- Lynch, C. P. (2007). Therese of Lisieux from the perspective of attachment theory and separation anxiety. *International Journal for the Psychology of Religion*, 17(1), 61-80.
- Mahler, M. S., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant: Symbiosis and individuation*. New York: Basic Books.
- Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened or frightening behavior the linking mechanism? In Sroufe, A. L. (2005). Attachment and development: A prospective longitudinal study from birth to adulthood. *Attachment and Human Development*, 7(4), 349-367.
- Main, M. & Hesse, E. (1990). Parent's unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. T. Greenberg, D. Cicchetti, & E. M. Cummins (Eds.), *Attachment in the preschool years: Theory, research, and intervention* (pp. 161-182). Chicago: University of Chicago Press.
- Main, M. & Salomon, J. (1986). Discovery of a new, insecure-disorganized/disoriented attachment pattern. In T. B. Brazelton & M. Yogman (Eds.), *Affective Development in infancy* (pp.95-124). Norwood, JJ: Ablex.
- Main, M. & Salomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth strange situation. In M. T. Greenberg D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years* (pp.121-160). Chicago: University of Chicago Press.
- Main, M. & Weston, D. R. (1982). Avoidance of the attachment figure in infancy: Descriptions and interpretations. In C. M. Parkes & J. Stevenson-Hinde (Eds.), *The place of attachment in human behavior* (pp. 31-50). New York: Basic Books.

- Mayer, B., Meesters C., & Muris, P. (2000). Self-reported attachment style, anxiety and depression in children. *Social Behavior and Personality*, 28(2), 157-162.
- Mowbray, C. T., Oyserman, D., Zemencuk, J.K. (1995). Motherhood for women with serious mental illness. *American Journal of Orthopsychiatry*, 65(1), 21-38.
- Naslund, B., Persson-Blennow, J., McNeil, T. (1984). Offspring of women with non-organic psychosis: Infant attachment to the mother at one year of age. *Acta Psychiatrica Scandinavica*, 69, 231-341.
- National Alliance for Research on Schizophrenia and Depression. (2008). *Schizophrenia*. Retrieved May 6, 2008 from <http://www.narsad.org/dc/schizophrenia/>.
- National Association of Mental Illness. (2003). *Understanding schizophrenia and recovery: What you need to know about this medical illness*. Retrieved July 2, 2007 from <http://www.nami.org/Content/ContentGroups/Helpline1/Schizophrenia.pdf>.
- National Association of Social Workers. (1996). Code of ethics. [Brochure] Washington, D.C.
- Neal, J. M., Weintraub, S. (1984). Social behavior of children at risk for schizophrenia. In Anthony, E. J., Rolf, J. E., Watt, N. F. & Wynne, L. C. (Eds.), *Children at risk for schizophrenia: A longitudinal perspective*. (pp.279-285). New York: Cambridge University Press.
- Padget, D. (1998). *Qualitative methods in social work research*. Thousand Oaks, CA: Sage.
- Peralta V. & Cuesta M. J. (1994). Lack of insight: Its status within schizophrenic psychopathology. *Biological Psychiatry* 36(8), 556-561.
- Powell, J. (1998). First person account: Paranoid Schizophrenia—A daughter's story. *Schizophrenia Bulletin*, 24, 175-177.
- Psychiatric Bulletin. (2007). *Schizophrenia*. Retrieved December 12, 2007 from [http://pb.rcpsych.org/cgi/search?andorexactfulltext=and&resourcetype=1&disp\\_type=&sortspec=relevance&author1=&fulltext=schizophrenia&pubdate\\_year=&volume=&firstpage=](http://pb.rcpsych.org/cgi/search?andorexactfulltext=and&resourcetype=1&disp_type=&sortspec=relevance&author1=&fulltext=schizophrenia&pubdate_year=&volume=&firstpage=).
- Radke-Yarrow, M. R., Cummings, E. M., Kuczynski, L., & Champman, M. (1985). Patterns of attachment in two-and-three-year-olds in normal families and families with parental depression. *Child Development*, 56(4), 884-893.

- Radke-Yarrow, M., Zahn-Waxler, C., Richardson, D.T., Susman, A. & Martinez, P. (1994). Caring behavior in children of clinically depressed and well mothers. *Child development*, 65(5), 1405-1414.
- Regier D. A., Narrow W. E., Rae D. S., Manderscheid R. W., Locke B. Z., Goodwin F. K. (1993). The de facto mental and addictive disorders service system: Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 50(2), 85-94.
- Sable, P. (2000). *Attachment and adult psychotherapy*. London: Jason Aronson.
- Schizophrenia Bulletin (2004). Schizophrenia Symptoms. Retrieved December 12, 2007 from <http://www.schizophrenia.com/diag.php#diagnosis>.
- Seifer R., Dickstein S., (1993). Parental mental illness and infant development. In Zeanah C. (ed.), *Handbook of infant mental health*. New York: Guilford.
- Sroufe, A. L. (2005). Attachment and development: A prospective longitudinal study from birth to adulthood. *Attachment and Human Development*, 7(4), 349-367.
- Stroebe, M. S. (2002). Paving the way: From early attachment to contemporary bereavement research. *Mortality*, 7(2), 127-138.
- Taylor, G. J. (1992). Psychosomatics and self-regulation. In J. W. Barron, M. N. Eagle, & D. L. Wolitsky (Eds.), *Interface of psychoanalysis and psychology* (pp.464-488). Washington D.C.: American Psychological Association.
- Webster, J. (1992) Split in two: experiences of the children of schizophrenic mothers. *British Journal of Social Work*, 22, 309-329.
- White, C. L., Nicholson, J., Fisher, W. H. (1995). Mothers with severe mental illness caring for children. *Journal of Nervous and Mental Disease*, 183(6), 398-403.
- White, K. (2004). Developing a secure-enough base: Teaching psychotherapists in training the relationship between attachment theory and clinical work. *Attachment & Human Development*, 6(2), 117-130.
- Winnicott, D. W. (1945) Primitive Emotional Development. In *Through Pediatrics to Psycho-Analysis*. (pp.145-156). London: The Hogarth Press and the Institute of Psychoanalysis.
- Winnicott, D. W. (1952) Anxiety associated with insecurity. In *Through Pediatrics to Psycho-Analysis*. (pp.97-100). London: The Hogarth Press and the Institute of Psychoanalysis.



Winnicott, D. W. (1960) The theory of the parent-infant relationship. In *The Maturation Process and the Facilitating Environment*. (pp.37-55). London: The Hogarth Press and the Institute of Psychoanalysis.

## Appendix A

### Human Subjects Review Approval Letter

December 27, 2007

Richard Cabada

Dear Richard,

Your second revisions have been reviewed and all is now fine. We are glad to give final approval to your study.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain signed consent documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

This is a very interesting topic and we hope you get a good response from your recruitment efforts. Good luck with your project. It should produce some very useful findings.

Sincerely,

Ann Hartman, D.S.W.  
Chair, Human Subjects Review Committee

CC: Mary Hall, Research Advisor

## Appendix B

### Informed Consent Form

My name is Richard Cabada. I am conducting a study designed to explore what we can learn from the practice wisdom of clinical practitioners about the subjective experience of children that have grown up in families where their primary caretaker is a mother who has been formally diagnosed as schizophrenic. Most of the literature about this population has been quantitative and tends to address this mother-child dyad from the subjective experience of the mother. This study is being conducted in partial fulfillment of the requirements for the Master of Social Work degree at the Smith College School for Social Work and for future presentations and publications.

To participate in this study one must be a licensed clinical practitioner, who has engaged in clinical work in this population and seen a minimum of three such cases. The actual clinical work with the client(s) may have been during childhood or with the child as an adult.

If you agree to participate in this study you would be required to meet in a face to face interview with me that would last no more than one hour. You will be asked a series of structured demographic questions followed by some open-ended questions that will probe your clinical experience. The interview will be tape recorded and I may take some additional notes during the interview. The tapes will be transcribed later and analyzed for recurrent themes by this researcher.

Strict confidentiality will be maintained, as consistent with federal regulations and the mandates of the social work profession. Your confidentiality will be protected by removing all names from interview tapes and transcripts and assigning numeric codes to these materials. You will be asked not to use names or identifying information when talking about any case in order to protect your clients' confidentiality. Information collected during the study will be reported in the aggregate only. Any illustrations or brief quotations included in the study will be sufficiently disguised to prevent identification of specific subjects. Consistent with federal regulations, all study materials will be kept in a secure location for a period of three years. After that time, tapes and transcripts will remain secured until no longer needed when they will be destroyed.

You will receive no financial benefit for your participation in this study. However, you may benefit from knowing that you have contributed to expanding the profession's knowledge base about the subjective experience of children who grow up in households where the primary caretaker is a mother who has been formally diagnosed as schizophrenic. There are few potential risks to participation in this study. However you should be aware that in any experience of self-reflection there is always the possibility that strong feelings may emerge which the participant may feel requires further attention.

Your participation is completely voluntary. You are free to refuse to answer any specific question(s) and/or to withdraw from the study at any time up until May 1, 2007 when the

research findings will be written up. If you decide to withdraw, all data describing you will be immediately destroyed.

Thank you again for your participation in this study. If you have any questions or wish to withdraw your consent, please contact:

Richard Cabada, MSW Intern  
Smith College School for Social Work  
Email: rcabada@smith.edu  
Mobile/VM #: 719-650-3131; Internship: 310 664-7815

or

Smith School for Social Work Human Subjects Review Committee  
VM#: 413-585-7974

**YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTION ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THIS STUDY.**

\_\_\_\_\_  
SIGNATURE OF PARTICIPANT

\_\_\_\_\_  
SIGNATURE OF RESEARCHER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

Please keep a copy of this *consent* form for your records.

Appendix C

Recruitment Letter

Date

Address

Dear \_\_\_\_\_,

Thank you for agreeing to participate in my study exploring the subjective experience of children that have grown up in households where the primary caretaker was a mother formally diagnosed as schizophrenic.

For your information, you will find enclosed a copy of the informed consent which you are required to sign. When we meet you will be asked to sign and date two copies of this informed consent and you will be given one for your personal records. Should you have any questions you can contact me by phone at 719-650-3131; or the Smith School for Social Work Human Subjects Review Committee at 413-585-7974. You will also have an opportunity to ask any remaining questions you may have at the time of the interview before signing this document.

I look forward to meeting with you on \_\_\_\_\_ (date) \_\_\_\_\_ at \_\_\_\_\_ (place) \_\_\_\_\_.

Sincerely,

Richard Cabada, MSW Intern  
Smith College School for Social Work

Appendix D

Demographic and Interview Questions

SECTION ONE: BRIEF STRUCTURED DEMOGRAPHIC QUESTIONNAIRE

1. Gender\_\_\_\_\_
2. Age\_\_\_\_\_
3. How do you identify yourself in terms of race, ethnicity or cultural identity?  
\_\_\_\_\_
4. Your professional degree(s), and when received? \_\_\_\_\_
5. Your professional license(s), and when received? \_\_\_\_\_
6. Number of years in direct clinical practice? \_\_\_\_\_
7. The number of settings in which you have worked as a professional clinical practitioner?

Type of setting	Number of years	Position
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Approximately how many cases would you say you have treated with a child that has been raised in a family where the primary caretaker is a mother that has been formally diagnosed as schizophrenic? (The actual clinical work with the client(s) may have been during childhood or with the child as an adult.)  
A. (note omission)      3-6 cases      7-10 cases      10+ cases

B. In which of the settings where you have worked did you work with this type of *case*? In general, how were such cases treated? (Please do not use names or identifying information when disclosing any case.)

---

## SECTION TWO: INTERVIEW GUIDE

1. Would you select a case that stands out for you where you were working with a child who grew up in a family where the primary caretaker was a mother who was formally diagnosed as schizophrenic? Tell me about the case. (Please do not use names or identifying information when talking about the case.)

Listening for:

Presenting problem

Who was seen?

What happened?

How do they understand the problem?

Methodology used to treat child

Outcome of case

2. How did the child perceive and make senses of their relationship with the mother in this case?

Listening for:

Attitude towards the mother.

Perceived strengths and weaknesses of mother.

What strategies did the child develop to deal with perceived weaknesses and were they adaptive or maladaptive.

3. Did the child know that the mother had been diagnosed as having a mental illness and, if so, what was their understanding of what this meant?

Listening for:

How did the child come to understand his mother's illness?

Was his understanding towards his mother positive or negative?

How did this understanding influence the child's relationship towards his mother?

4. How typical is this case of all the cases you have treated where you were working with children that have grown up in households where the primary caretaker was a mother that has been formally diagnosed as schizophrenic? In what way has your treatment experience with this population varied? (Please do not use names or identifying information when talking about any of your previous cases.)

Listening for:

Have you been able to identify other variations in the other cases you have treated?

Are there other variations in terms how the child perceives the illness?

5. Based on your clinical experience, is there anything else you would like to tell me about the *subjective* experience of children who grew up in households where the primary caretaker was a mother who has been formally diagnosed as Schizophrenic?